		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043521

Facility Name: Dogwood Health Care Center

Address: 902 East Arnold Street (Number) Sandwich (City) 60548 (Zip Code)

County: Dekalb

Telephone Number: (815) 786-8409 **Fax #** (815) 786-3830

IDPA ID Number: 830320180012

Date of Initial License for Current Owners: 2/7/1998

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317)566-1586

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) William H. Keys
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Chris Murphy, CPA, Partner
(Firm Name & Address) BKD, LLP, 6120 S. Yale, Suite 1400
(Telephone) (918) 584-2900 Fax # (918) 584-2931

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	23,058	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	23,058	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,120	6,696	0	16,816	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,120	6,696		16,816	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.93%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/7/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	111,032	7,238	3,850	122,120		122,120		122,120			1
2	Food Purchase		79,564		79,564		79,564	(717)	78,847			2
3	Housekeeping	80,846	4,735		85,581		85,581		85,581			3
4	Laundry	22,927	5,153		28,080		28,080	(189)	27,891			4
5	Heat and Other Utilities			60,948	60,948		60,948	(2,501)	58,447			5
6	Maintenance	41,217	6,371	14,756	62,344		62,344	1,184	63,528			6
7	Other (specify):* Waste Removal			4,356	4,356		4,356		4,356			7
8	TOTAL General Services	256,022	103,061	83,910	442,993		442,993	(2,223)	440,770			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	616,454	32,229	68,915	717,598		717,598	4	717,602			10
10a	Therapy											10a
11	Activities	28,129	1,519	2,860	32,508		32,508		32,508			11
12	Social Services	25,399		2,775	28,174		28,174		28,174			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Non allow cost											15
16	TOTAL Health Care and Programs	669,982	33,748	85,350	789,080		789,080	4	789,084			16
	C. General Administration											
17	Administrative			66,452	66,452		66,452		66,452			17
18	Directors Fees											18
19	Professional Services			23,561	23,561		23,561	13,332	36,893			19
20	Dues, Fees, Subscriptions & Promotions			29,549	29,549		29,549	(5,203)	24,346			20
21	Clerical & General Office Expenses	61,074	8,152	11,064	80,290		80,290	162,255	242,545			21
22	Employee Benefits & Payroll Taxes			170,002	170,002		170,002		170,002			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,337	6,337		6,337	2,700	9,037			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,793	47,793		47,793	19	47,812			26
27	Other (specify):*											27
28	TOTAL General Administration	61,074	8,152	354,758	423,984		423,984	173,103	597,087			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	987,078	144,961	524,018	1,656,057		1,656,057	170,884	1,826,941			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Dogwood Health Care Center #0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			61,762	61,762		61,762	360	62,122			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							3	3			32
33	Real Estate Taxes			25,152	25,152		25,152	26	25,178			33
34	Rent-Facility & Grounds							1,418	1,418			34
35	Rent-Equipment & Vehicles			5,478	5,478		5,478	144	5,622			35
36	Other (specify):* See Attached			257	257		257		257			36
37	**TOTAL Ownership**			92,649	92,649		92,649	1,951	94,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,520		1,520		1,520		1,520			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,588	34,588		34,588		34,588			42
43	Other (specify):* Lab & Rad											43
44	**TOTAL Special Cost Centers**		1,520	34,588	36,108		36,108		36,108			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	987,078	146,481	651,255	1,784,814		1,784,814	172,835	1,957,649			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(403)	02		4
5	Telephone, TV & Radio in Resident Rooms	(2,501)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(314)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(420)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,341)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Revenue				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,979)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	181,814	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 181,814		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 172,835		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Dogwood Health Care Center

ID# 0043521

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other-Attach Schedule - Goodwill	$ 0		1
2	Other-Attach Schedule - Other non allowable exp	0		2
3	Other-Attach Schedule - Vending revenue	0		3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(717)	0	0	0	0	0	0	0	0	0	0	(717)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(189)	0	0	0	0	0	0	0	0	0	(189)	4
5	Heat and Other Utilities	(2,501)	0	0	0	0	0	0	0	0	0	0	(2,501)	5
6	Maintenance	0	1,184	0	0	0	0	0	0	0	0	0	1,184	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,218)	995	0	0	0	0	0	0	0	0	0	(2,223)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4	0	0	0	0	0	0	0	0	0	4	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4	0	0	0	0	0	0	0	0	0	4	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(420)	13,752	0	0	0	0	0	0	0	0	0	13,332	19
20	Fees, Subscriptions & Promotions	(5,341)	138	0	0	0	0	0	0	0	0	0	(5,203)	20
21	Clerical & General Office Expenses	0	162,255	0	0	0	0	0	0	0	0	0	162,255	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,700	0	0	0	0	0	0	0	0	2,700	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	19	0	0	0	0	0	0	0	0	19	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,761)	176,145	2,719	0	0	0	0	0	0	0	0	173,103	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,979)	177,144	2,719	0	0	0	0	0	0	0	0	170,884	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	360	0	0	0	0	0	0	0	0	360	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	3	0	0	0	0	0	0	0	0	3	32
33	Real Estate Taxes	0	0	26	0	0	0	0	0	0	0	0	26	33
34	Rent-Facility & Grounds	0	0	1,418	0	0	0	0	0	0	0	0	1,418	34
35	Rent-Equipment & Vehicles	0	0	144	0	0	0	0	0	0	0	0	144	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	1,951	0	0	0	0	0	0	0	0	1,951	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,979)	177,144	4,670	0	0	0	0	0	0	0	0	172,835	45

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Organizational Structure						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100.00%	0		2
3	V	3	Housekeeping		Senior Living Properties, LLC	100.00%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100.00%	(189)	(189)	4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	0		5
6	V	6	Maintenance		Senior Living Properties, LLC	100.00%	1,184	1,184	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	4	4	8
9	V	10a	Therapy		Senior Living Properties, LLC	100.00%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100.00%	0		10
11	V	19	Professional Services		Senior Living Properties, LLC	100.00%	13,752	13,752	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	138	138	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	162,255	162,255	13
14	Total			$			$ 177,144	$ * 177,144	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits & Payroll Taxes	$	Senior Living Properties	100.00%	$ 0	$	15
16	V	24	Travel and Seminar		Senior Living Properties	100.00%	2,700	2,700	16
17	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties	100.00%	19	19	17
18	V	30	Depreciation		Senior Living Properties	100.00%	360	360	18
19	V	32	Interest		Senior Living Properties	100.00%	3	3	19
20	V	33	Real Estate Taxes		Senior Living Properties	100.00%	26	26	20
21	V	34	Rent - Facility & Grounds		Senior Living Properties	100.00%	1,418	1,418	21
22	V	35	Rent - Equipment & Vehicles		Senior Living Properties	100.00%	144	144	22
23	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties	100.00%	0		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 4,670	$ * 4,670	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12900 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317)566-1586
Fax Number: (317) 581-9513

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	See Attachment	See Attachment	See Attachment	$ 0	$	See Attachment	$ 0	1
2	2	Food Purchase	See Attachment	See Attachment	See Attachment	0		See Attachment	0	2
3	3	Housekeeping	See Attachment	See Attachment	See Attachment	0		See Attachment	0	3
4	4	Laundry	See Attachment	See Attachment	See Attachment	(14,096)		See Attachment	(189)	4
5	5	Heat and Other Utilities	See Attachment	See Attachment	See Attachment	0		See Attachment	0	5
6	6	Maintenance	See Attachment	See Attachment	See Attachment	95,381		See Attachment	1,184	6
7	7	Waste Removal	See Attachment	See Attachment	See Attachment	0		See Attachment	0	7
8	10	Nursing & Medical Records	See Attachment	See Attachment	See Attachment	267		See Attachment	4	8
9	10a	Therapy	See Attachment	See Attachment	See Attachment	0		See Attachment	0	9
10	17	Administrative	See Attachment	See Attachment	See Attachment	0		See Attachment	0	10
11	19	Professional Services	See Attachment	See Attachment	See Attachment	1,026,001		See Attachment	13,752	11
12	20	Dues, Fees, Subscriptions & Prom	See Attachment	See Attachment	See Attachment	10,855		See Attachment	138	12
13	21	Clerical & General Office Expens	See Attachment	See Attachment	See Attachment	12,021,375		See Attachment	162,255	13
14	22	Employee Benefits & Payroll Tax	See Attachment	See Attachment	See Attachment	0		See Attachment	0	14
15	24	Travel and Seminar	See Attachment	See Attachment	See Attachment	272,954		See Attachment	2,700	15
16	26	Insurance - Prop Liab Malpractic	See Attachment	See Attachment	See Attachment	1,435		See Attachment	19	16
17	30	Depreciation	See Attachment	See Attachment	See Attachment	26,841		See Attachment	360	17
18	32	Interest	See Attachment	See Attachment	See Attachment	249		See Attachment	3	18
19	33	Real Estate Taxes	See Attachment	See Attachment	See Attachment	1,914		See Attachment	26	19
20	34	Rent-Facility & Grounds	See Attachment	See Attachment	See Attachment	105,820		See Attachment	1,418	20
21	35	Rent-Equipment & Vehicles	See Attachment	See Attachment	See Attachment	10,725		See Attachment	144	21
22	36	Loss, Goodwill, & Depreciation	See Attachment	See Attachment	See Attachment	0		See Attachment	0	22
23										23
24										24
25	TOTALS					$ 13,559,723	$		$ 181,814	25

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.		$ 20,892	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 20,892	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 25,152	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 25,152	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	24,029	8
	2000	8,104	9
	2001	47,127	10
	2002	54,213	11
	2003	53,393	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dogwood Health Care Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0043521

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317)566-1586 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-25-252-015	See Attached	$ 28,923.52	$ 28,923.52
2.	19-25-252-016	See Attached	$ 24,469.06	$ 24,469.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 53,392.58	$ 53,392.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,626 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	94,961	1998	$ 29,177	1
2					2
3	TOTALS	94,961		$ 29,177	3

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	63		1998	1973	$ 954,276	$ 31,809	30	$ 31,809	$	$ 220,014	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Duct work			1998	721	36	20	36		222	9
10	Duct work			1998	1,842	184	10	184		1,259	10
11	Deck Mount Faucet			1998	2,043	136	15	136		863	11
12	Faucet & Valves			1998	3,100	207	15	207		1,292	12
13	Vanity & Marble			1998	5,046	505	10	505		3,238	13
14	Sump Pump			1998	1,990	199	10	199		1,360	14
15	Fluorescent Light Fixtures			1998	1,046	52	20	52		327	15
16	Sewer Repair			1999	1,280	85	15	85		434	16
17	89 Gallon Commercial Water Heater			1999	5,045	505	10	505		2,565	17
18	Walk-In Refrigerator/Freezer			1999	18,780	1,878	10	1,878		9,547	18
19	Furnace			1999	2,985	199	15	199		1,012	19
20	Nurse Call System			1999	17,348	1,735	10	1,735		8,819	20
21	Lighting Fixtures			1999	1,570	157	10	157		942	21
22	Alarm / Intercom system			1999	11,913	1,191	10	1,191		8,400	22
23	Install second intercom			1999	11,913	1,191	10	1,191		8,400	23
24	Plumbing repair			1999	1,800	90	20	90		488	24
25	Lighting Fixtures			1999	849	85	10	85		460	25
26	Light Fixture			1999	952	95	10	95		515	26
27	Window tinting			1999	1,432	215	5	215		1,432	27
28	Hot Water Heater			2003	4,895	490	10	490		530	28
29	Land Improvement			1998	12,175	812	15	812		5,614	29
30	Signage			1998	464	46	10	46		305	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,063,465	$ 41,902		$ 41,902	$	$ 278,038	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 167,150	$ 19,654	$ 19,654	$	Various	$ 141,843	71
72	Current Year Purchases	5,372	206	206		Various	206	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 172,522	$ 19,860	$ 19,860	$		$ 142,049	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,265,164	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 61,762	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,762	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 420,087	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,478 Description: Nursing - 285, Dietary - 1048, Plant - 524, Administrative - 3622
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	$	0	$ 0	$ 0		$	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		0	0	0			2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		0	0	0			4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (6,353)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	204,912		3
4	Supply Inventory (priced at)	10,753		4
5	Short-Term Investments	(906)		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 208,406	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,177		13
14	Buildings, at Historical Cost	1,050,825		14
15	Leasehold Improvements, at Historical Cost	12,639		15
16	Equipment, at Historical Cost	172,523		16
17	Accumulated Depreciation (book methods)	(420,087)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Intercompany**			22
23	Other(specify): **Intercompany (Pay)/Rec**	(2,488,771)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (1,643,694)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,435,288)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 18,265	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,061		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,217		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,152		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Accrued Expenses**			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 122,695	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 122,695	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,557,983)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,435,288)	$	48

***(See instructions.)**

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,662,765)	1
2	Restatements (describe):		2
3	**Accounting Adjustments**	256,546	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,406,219)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(151,764)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (151,764)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,557,983)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,691,738	1
2	Discounts and Allowances for all Levels	(1,061,692)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,630,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	403	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,601	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,004	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending		28
28a	Vending		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,633,050	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	442,993	31
32	Health Care	789,080	32
33	General Administration	423,984	33
	B. Capital Expense		
34	Ownership	92,649	34
	C. Ancillary Expense		
35	Special Cost Centers	1,520	35
36	Provider Participation Fee	34,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,784,814	40
41	**Income before Income Taxes (line 30 minus line 40)****	(151,764)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (151,764)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	0	0	$ 0	$	1
2	Assistant Director of Nursing	1,098	1,249	29,611	23.71	2
3	Registered Nurses	5,371	5,929	129,046	21.77	3
4	Licensed Practical Nurses	5,704	6,142	128,492	20.92	4
5	Nurse Aides & Orderlies	24,422	26,978	317,956	11.79	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,715	1,861	22,791	12.25	9
10	Activity Assistants	741	792	5,338	6.74	10
11	Social Service Workers	1,804	1,918	25,399	13.24	11
12	Dietician	1,928	2,150	33,853	15.75	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	8,403	9,100	77,179	8.48	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,473	2,750	41,217	14.99	17
18	Housekeepers	7,506	8,366	80,846	9.66	18
19	Laundry	2,899	3,127	22,927	7.33	19
20	Administrator					20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	3,880	4,250	61,074	14.37	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	807	902	11,349	12.58	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	68,751	75,514	$ 987,078 *	$ 13.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 3,850	1, 3	35
36	Medical Director	0	10,800	9, 3	36
37	Medical Records Consultant			10, 3	37
38	Nurse Consultant			10, 3	38
39	Pharmacist Consultant	48	1,679	10, 3	39
40	Physical Therapy Consultant			10a, 3	40
41	Occupational Therapy Consultant			10a, 3	41
42	Respiratory Therapy Consultant			10a, 3	42
43	Speech Therapy Consultant			10a, 3	43
44	Activity Consultant	28	2,860	11, 3	44
45	Social Service Consultant	28	2,775	12, 3	45
46	Other(specify) Administrative Consu	2,080	66,172	17,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,280	$ 88,136		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,080	$ 53,593	10,3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,080	$ 53,593		53

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Contract Services: Administrator	$ 66,172
Misc. Fees	280
TOTAL (agree to Schedule V, line 17, col. 3)	$ 66,452
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 420
Patient Litigation	Various	0
Payroll Processing	Various	3,432
Accounting	Various	3,530
EDP Services	Various	16,179
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 23,561

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,602
Unemployment Compensation Insurance	0
FICA Taxes	113,395
Employee Health Insurance	(8)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,013
TOTAL (agree to Schedule V, line 22, col.8)	$ 170,002

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,193
Health Care Worker Background Check	680
(Indicate # of checks performed 52)	
Dues & Subscriptions	19,197
Advertising & Public Relations	5,341
Home Office Allocation	138
Less: Public Relations Expense	( )
Non-allowable advertising	(5,203)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,346

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,644
Seminar Expense	552
Business Meals	141
Home Office Allocation	2,700
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,037

**See instructions.

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Dogwood Health Care Center # 0043521 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. 0 N/A

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 7,161 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 34,588
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? Yes Indicate the amount. $ 403

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.